Catholic Health Australia

# Submission to Productivity Commission Inquiry into a National Disability Long-term Care and Support Scheme

August 2010

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**About Catholic Health Australia**

21 public hospitals, 54 private hospitals, and 550 aged care services are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

# 1. Introduction

*"There are two million Australians either living with a severe or profound disability or, indeed, caring for a person with a severe or profound disability as their primary care."* (The Hon Bill Shorten, Parliamentary Secretary for Disabilities and Children's Services).

The time has come for the way services for people with disabilities are funded and structured in Australia to change by making them effective, equitable, efficient and accessible. The welfare-based charity approach to disability services is out of step with the needs and desires of people with disabilities and their families.

Support services and resource allocation should be based on need with access to services being an entitlement. CHA considers that a National Disability Insurance Scheme (NDIS) should be introduced as a central plank of an Australian Government National Disability and Aged Care Support Program.

Many CHA members are providers of services for people living with a congenital or acquired disability needing long term care and support.

CHA members have direct knowledge and experience of the fragmented nature of the current arrangements for caring for people with an acquired or congenital disability as they age. The fragmentation in current arrangements is accompanied by:

- inadequate resourcing, gaps in services and uneven access to services across different locations and States and Territories;
- inequity of treatment and eligibility;
- most importantly, lack of certainty of continuity of services as care and support needs change with age; and
- lack of choice of services.

These issues also pertain generally to the total population of people living with a profound or severe disability.

# 2. Eligibility criteria for the Scheme

People with permanent disabilities regardless of when the disability is acquired and how acquired should be eligible. CHA considers that disabilities acquired as a result of the ageing process should not be excluded from the eligibility criteria.

The scheme should be a No-fault scheme and apply to those with profound and severe disabilities as well as those with more moderate disabilities. People born with a disability or who acquire a permanent disability through an accident, injury or as a result of a medical condition, including mental illness, should be eligible.

Eligibility for the scheme would not replace legal action for negligence or culpable behaviour resulting in the acquisition of a disability.

## 3. Coverage and entitlements

The scheme would cover the cost of a package of care services including therapy, aids and appliances, accommodation support, transport and a range of community participation programs available for a person's lifetime. It would not cover income support or housing.

Services would be person-centred based on the needs and choices of each person with a disability and their family. Where appropriate, case management to facilitate independence, maximise potential and plan transitions over the life course would be funded by the scheme when required.

Early intervention would be a top priority with aids, equipment and home modification needs met on a timely basis.

## 4. Choice of care providers

People with disabilities and their carers should have a choice of approved care providers and have the opportunity to participate in their care planning and delivery. Many people with disabilities would welcome being able to direct the care they need and receive.

Providers would include public as well as incorporated organisations that are from the for-profit and not-for-profit sectors.

## 5. Informal care

Families would continue to fulfill normal age-appropriate caring roles with tailored support for carers, through respite, information, counselling, training and education based on family structure and disability.

Families need to be able to choose to work or provide informal care, in the same way as for families without disabled members, however part-time work and labour force engagement needs to be facilitated through the way the system is funded and managed.

## 6. Implications for the health and aged care systems

In the same way that aged care is about supporting people who are acquiring disabilities and undergoing functional decline, the disability support program has many of the same characteristics.

Disability care and support and aged care should be complementary programs integrating where client choice of services and community support provides such a foundation. Clear linkages into the nation's health system need to be spelt out and transparent.

A universal national disability care and support insurance scheme would be an entitlement scheme where all those assessed as eligible for care and support would receive it. This would contrast with the current aged care system which incorporates a strong gate-keeping entry with access to care being rationed due to the Commonwealth's place planning and allocation process.

While there are separate disability and aged care programs, there are also some programs which cover both groups. Added to this is the significant complication that the disability programs are even more underfunded than the aged care programs.

There are two basic options to address the current fragmented arrangements. The effectiveness of either option, however, would be compromised without adequate funding to meet need which avoids the necessity to ration services. The two options are:

a) Create a national aged care and disability program which would encompass all people with long term care needs irrespective of age and the cause of frailty and disability.
b) Create two national parallel programs to address disability and aged care services separately, with the former designed to ensure lifelong care and support for people with congenital or acquired disabilities, and the latter designed to ensure care and support for people assessed in need of care due to frailty as a result of ageing.

The advantage of separate parallel national programs is that it would provide the opportunity to create a universal entitlement-based national disability scheme which has common needs based assessment and funding entitlements based on need, consistent eligibility criteria, consistent client contribution policies based on standardized capacity to pay criteria and consistent quality assurance, accreditation, reporting, transparency and accountability arrangements, to mirror that which is more evolved in the aged care sector under the *Aged Care Act 1997.* The existence of national policies on these issues would not preclude administration of the program at State and Territory level.

As a result of the health and aged care reforms flowing out of the Council of Australian Governments (COAG) April 20 2010 National Health and Hospitals Network Agreement, the Commonwealth assumes responsibility for the community and aged care for people aged 65 years and over and also funding of specialist disability services for this same target aged group.

Using the age of 65 as the criteria for separating regulating and funding responsibilities whilst the planning and allocations of aged care places is based on a ratio formula of people aged 70+ will create potentially a greater dissonance between place supply and demand.

How the rationed aged care program will allow seamless transition from the entitlement based NDIS as people with disabilities reach age 65 will be one of the potential matters for the Commission to consider. To assist in seamless transition, the National Disability Standards should incorporate a requirement for disability service providers to pursue transition planning for those persons needing to have access to the most appropriate service options regardless of which level of government is providing the funding and controls the funding program boundaries.

The Commission also needs to consider:

- the mismatch between funding arrangements that would apply in the NDIS and the aged care program;
- that people over 65 years living in supported accommodation may be vulnerable to pressure to move as the costs associated with living in residential aged care are generally lower;
- how the scheme and the aged care One Stop Shops will deal with assessing and responding to changing needs; and
- the interface between the different quality standards.

## 7. Employment services and income support

A goal of the NDIS should be to maximise the opportunities for people with disabilities to work, facilitated through active case management to achieve as normal a life as possible and to minimise the risks of over-dependence on publicly funded support.

## 8. Governance

A governance framework needs to be established to manage scheme assets, liabilities and data collections to optimise scheme performance and monitor usage. The framework would include national standards of assessment, care, support and case management.

Active claims management would incorporate an independent review/appeals process.

Payment for care and support would be on an assessment of the services a person needs with payments meeting the sustainable costs of those services using an activity based funding model.

## 9. Financing of the Scheme

As an insurance-based scheme, providing cover to Australians as and when they needed it, an NDIS would be funded by all taxpayers through general revenue or an extension of the Medicare insurance levy. An insurance-based approach to disability services stems from the view that disability is a "risk" that can strike anyone in our society, with potentially catastrophic consequences if proper support services are not in place, but will not affect everyone. The national pooling of risks is an integral component to the scheme.

# 10. Conclusion

An NDIS would create major employment and business opportunities, as well as meeting the needs of people with disabilities, their families and carers. It would also reduce costs in the medium and long term by eliminating many of the inequities and inefficiencies in the current welfare-based system.

The insurance approach would create an automatic alignment between the interests of people with disabilities, families, carers, the community and governments built on maximising opportunities and minimising costs over the life course. For example, a life-time approach to care would ensure that early intervention, therapy, equipment and home modifications are available as soon as they are needed following diagnosis or injury, leading to better and lower cost long-term outcomes.

Families of people with disabilities would have confidence that the needs of their family member would be met, reducing unnecessary stress and risks of family breakdown, which are currently adding significantly to costs of the current system.

***References:***

NDIS, *The Plan for a National Disability Scheme* (NDIS), www.ndis.org.au, July 2009

Catholic Health Australia, *Submission to Senate Community Affairs Committee Inquiry into Planning Options and Services for People Ageing with a Disability,* May 2010

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